

# Primary Amebic Meningoencephalitis Case Report Form

## Report Source

Date Reported to CHD: \_\_\_\_\_ Reporting Source (Check all that apply):  Lab  Hospital  Physician  Public Health Agency  Other \_\_\_\_\_

Reporter name: \_\_\_\_\_ Reporter phone: \_\_\_\_\_

## Demographic Information

Patient's Last Name	First	M.I.	Date of Birth / /	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown
Address			City	State	Zip
Phone Number:					
Occupation/Grade Level	Place of Employment/School/Daycare	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian/PI <input type="checkbox"/> Am. Indian <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	

## Clinical Information

Date Diagnosed: / /	Date/Time of Onset: / / _____ a.m. / p.m.	Date/Time of Recovery: / / _____ a.m. / p.m.	Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No Dates: _____ to _____ Drug(s): _____ _____ Dates: _____ to _____ Drug(s): _____
M.R. #:	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ER only		Admission Date: / / Discharge Date: / /
Hospital Info: _____ ( ) _____		Outcome: <input type="checkbox"/> Recovered <input type="checkbox"/> Died / /	Physician Info: _____ ( ) _____
Symptoms: <input type="checkbox"/> headache <input type="checkbox"/> fever <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> stiff neck	<input type="checkbox"/> confusion <input type="checkbox"/> loss of balance <input type="checkbox"/> loss of bodily control <input type="checkbox"/> lack of attention to people and surroundings <input type="checkbox"/> seizures <input type="checkbox"/> hallucinations	Laboratory Information: _____ _____ _____	Specimen Type: <input type="checkbox"/> Cerebral Spinal Fluid <input type="checkbox"/> Brain Tissue <input type="checkbox"/> Other _____  Confirmed by State Lab: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> NA
		Date Collected: / /	Lab Report Date: / /
		Results: _____ _____  Confirmed by CDC Lab: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> NA	

## Risk Factors

<p>Yes No Don't Know NA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Recreational water exposure</p> <p><input type="checkbox"/> Man-made Lake <input type="checkbox"/> Freshwater Lake <input type="checkbox"/> River <input type="checkbox"/> Canal <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Wading pool <input type="checkbox"/> Spa <input type="checkbox"/> Pond <input type="checkbox"/> Water park <input type="checkbox"/> Fountain <input type="checkbox"/> Hot springs <input type="checkbox"/> Other: _____</p> <p>Exposure Date: / /</p> <p>Source: _____</p> <p>Location of water activities: _____</p> <p>Water Temp: _____ F/C Ambient Air Temp: _____ F/C</p> <p>Estimated Depth: _____ Turbidity: _____</p> <p>Water level: _____ If treated water, chlorine level: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Did person dive into the water? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Did person jump into the water? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Did person swim in the water?</p>	<p>Yes No Don't Know NA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Did person participate in other water sports? Which _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Did person splash in the water? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Did person inhale any water up the nose? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Did person swallow any water? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Did person wear a nose clip or hold your nose shut when jumping or diving in the water? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Did you see any signs posted regarding "No Swimming"? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Do any power plants dump water into the water? or Are any power plants located near the water? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Did person have any contact with soil/sand? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Were you aware of the health risks associated with swimming in warm man-made/fresh water lakes? If yes, how: <input type="checkbox"/> Healthcare Provider <input type="checkbox"/> Newspaper <input type="checkbox"/> TV <input type="checkbox"/> Radio <input type="checkbox"/> Health Department <input type="checkbox"/> Friend/Relative <input type="checkbox"/> Sign <input type="checkbox"/> Prior to Illness <input type="checkbox"/> After Illness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Did you know of press releases warning about the risks?</p>
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Most likely exposure/site: \_\_\_\_\_ Site Name/address: \_\_\_\_\_

Where did exposure probably occur? State and County: \_\_\_\_\_  US but not \_\_\_\_\_  Outside US  Unknown

Investigator: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_